SECTION 4

EMPLOYEE ORIENTATION

FOR A PRINTABLE VERSION OF ALL FORMS, PLEASE GO TO THE OPEHI'S WEBSITE AT:

http://personnel.ky.gov/hlthins/adminifo.htm.

Employee Orientation Materials

This Section has been designed to assist Insurance Coordinators with the enrollment of new employees. All new employees should receive the following information:

___ Health Insurance Handbook

___ Health Insurance Application

___ Flexible Spending Account Handbook, if applicable

___ Flexible Spending Account Application, if applicable

___ Initial COBRA Memorandum (Refer to page 4-4 or Appendix A-1)

___ Memorandum regarding Notice about Special Enrollment Rights and Notice about Women's Health and Cancer Right Acts (this notice is required by Federal guidelines) (Refer to page 4-8).

___ Health Insurance Checklist (Refer to page 4-9). Every new employee should be given this checklist for review and he/she should check each item as explained to him/her by the Insurance Coordinator. This checklist ensures that each employee has received the required information and protects the Insurance Coordinator in the event of a discrepancy.

Copies of the memorandum, checklist and all applications should be maintained in the employee's personnel file.

Health Insurance Checklist

Coordinator Information

A Health Insurance Checklist form is included in this Section (page 4-9) to ensure consistency in the explanation of Health Insurance and Flexible Spending Account benefits.

- This form has been designed to cover essential health insurance information that MUST be given to the employee during the initial benefit orientation session.

- The completed Checklist, along with the appropriate copies of the health insurance application, Flexible Spending Account enrollment form, etc., should be made a part

of the employee's personnel file as acknowledgement of receipt of information. A copy of all forms should be given to the employee once they have been completed.

- If your organization is already using a benefit orientation form, incorporate all topics included on this Checklist.

- On the last page of the Health Insurance Checklist, the employee must respond to the question regarding previous employment within the last sixty-three (63) days with another agency participating in the Public Employee Health Insurance Program.

    - If the employee's break in service is greater than sixty-three (63) days, then the employee can make any elections (treat as a new employee).

    - If the employee's break in service is less than sixty-three (63) days, the employee cannot change his/her previous elections unless he/she experienced a Qualifying Event giving rise to a permitted mid-year election change.

The OPEHI is not attempting to alter your agency's policies pertaining to effective dates and payroll issues. You may consider an employee to be a "new employee" instead of a "transferring employee", but the employee will not be permitted to make election changes without a sixty-three (63) day break in service.

M E M O R A N D U M

TO: _____

(Eligible Employee and Spouse, if any)

_____

(Employee's Social Security Number)

FROM:

Insurance Coordinator

DATE:

GENERAL NOTICE OF RIGHT TO CONTINUE GROUP HEALTH INSURANCE COVERAGE

On April 7, 1986, a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you of your rights and obligations under the COBRA provisions of the law. **Both you and your spouse should take the time to read this section carefully.**

If you are an eligible member under the Commonwealth of Kentucky's Public Employee Health Insurance Program, you have a right to choose temporary continuation coverage if you lose your group health insurance coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse or dependent child of an employee covered by the Plan, you have the right to choose temporary continuation coverage for yourself if you lose group health insurance coverage under the Plan for *any* of the following reasons:

(1) death of your spouse/employee;
(2) termination of your spouse's/employee's employment (for reasons other than gross misconduct) or a reduction in your spouse's/employee's hours of employment;
(3) divorce or legal separation from your spouse;
(4) your spouse becomes entitled to Medicare or
(5) dependent child ceases to be eligible under the spouse/employee Plan.

Definition of Qualified Beneficiary – A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is an employee, the employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

"Qualifying events" are certain events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA.

Your Responsibilities – Under the law, you and your family member(s) have the responsibility to inform your Insurance Coordinator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the date of the event.

The Commonwealth has the responsibility to notify your Insurance Coordinator of the employee's death, termination of employment, reduction in hours of employment, or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if the Commonwealth commences a bankruptcy proceeding and these individuals lose coverage.

When your Insurance Coordinator is notified that one of these events has happened, your Insurance Coordinator will, in turn, notify you that you have the right to choose temporary continuation coverage. Under the law, you have at least 60 days from the date you lose coverage because of one of the events described above to inform your Insurance Coordinator that you want temporary continuation coverage. If you do not choose temporary continuation coverage on a timely basis, your group health insurance coverage under the Plan will end.

If you choose temporary continuation coverage, the Commonwealth is required to provide you coverage; as of the time coverage is being provided, identical to the coverage provided under the Plan. A change in the plan for active employees will also apply to qualified beneficiaries. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost your group health insurance coverage because of a termination of employment or a reduction in hours worked. In that case, the required temporary continuation coverage period is 18 months. The 18 months may be extended to 36 months if another qualifying event (such as death, divorce, legal separation, or Medicare entitlement) occurs during the original 18-month period.

Disability Extension – Qualified beneficiaries who wish to take advantage of the 11-month disability extension must notify plan administrators of the disabled qualified beneficiary's Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the initial 18-month period of COBRA coverage. These beneficiaries also must notify the employee's insurance coordinator within 30 days if the qualified beneficiary is determined by Social Security to be no longer disabled.

In no event will temporary continuation coverage last beyond 36 months from the date of the original qualifying event that made a qualified beneficiary eligible to elect temporary continuation coverage.

Termination of Coverage - However, the law also provides that your temporary continuation coverage may be terminated for *any* of the following reasons:

(1) the Commonwealth no longer provides group health insurance coverage to any of its employees;
(2) the required premium for your temporary continuation coverage is not paid on time;
(3) after the date that temporary continuation coverage is elected, the qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
(4) after the date that temporary continuation coverage is elected, the qualified beneficiary becomes entitled to Medicare; or
(5) a qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Duration of COBRA Coverage – There are situations in which a group health plan may terminate temporary continuation coverage earlier than usually permitted. One of these situations is where the qualified beneficiary obtains coverage under another group health plan. However, if the other group health plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's termination based on other coverage rules, as follows. If a group health plan limits or excludes benefits for pre-existing conditions, but because of the HIPAA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA coverage, then the plan providing COBRA coverage may terminate your COBRA coverage.

You do not have to show that you are insurable to choose temporary continuation coverage. Under the law, you may have to pay all or part of the premium for your temporary continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. At the end of the 18 month, 29 month, or 36 month temporary continuation coverage period, qualified beneficiaries will be allowed to enroll in an individual conversion health insurance plan provided under the terms of the Plan.

If you have any questions about COBRA, please contact _____, your Insurance Coordinator. Also, if you have changed your marital status, or you or your spouse has changed addresses, please notify your Insurance Coordinator.

M E M O R A N D U M

TO: New Employees or Prospective Health Insurance Enrollees

FROM: (Name of State Agency, Board of Education, Local Health Department, KCTCS, etc.)

DATE:

NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself; your spouse and/or any of your eligible dependents because of other group health insurance coverage, you may be able to make a mid-year change in the Public Employee Health Insurance Program if you/they lose the other group health coverage. If other group health coverage is lost, you must request enrollment in the Public Employee Health Insurance Program no later than thirty (30) days of the loss.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or the placement for adoption, you may be able to enroll yourself; spouse; and/or your dependents in the, Public Employee Health Insurance Program provided that you request enrollment within thirty (30) days of the date of the event. You will have sixty (60) days from the date of birth to add newborns. However, if you choose to add other eligible dependents at that time (birth of newborn), the change must be made no later than thirty (30) days.

NOTICE ABOUT WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Right's Act requires the Commonwealth to notify you, as a participant in the Public Employee Health Insurance Program, of your rights related to benefits provided through the program in connection with a mastectomy. You have rights to coverage provided in a manner determined in consultation with your attending physician for:

(1) all stages of reconstruction of the affected breast ;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the plan's regular deductible, if any, and applicable co-payment or co-insurance amounts, depending upon the plan type and coverage option you have selected. For further details, please refer to your certificate of coverage.

Keep this notice for your records.

HEALTH INSURANCE CHECKLIST

NAME – LAST	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO.

AGENCY NAME	HIRE DATE MO DAY YR	WORK PHONE ( )	CO. OF RESIDENCE	COMPANY NUMBER

Following is a list of your rights and responsibilities regarding the Public Employee Health Insurance Program. Read this form carefully and make sure you understand each item. You may direct your questions to the Insurance Coordinator or the Office of Public Employee Health Insurance.

As a new employee I understand:

___ I have thirty (30) days from my date of employment, or _____ (date specified by your employer) in which to enroll in one of the available health insurance plans.

___ I must submit all applications for health insurance (or waiver) and Flexible Spending Accounts to my agency's Insurance Coordinator.

___ I must choose a plan that is available in the county where I live, work or that is designated as a Contiguous county for purposes of health insurance only. (See Availability Chart in your *Health Insurance Handbook*. If I live outside the Commonwealth of Kentucky, I must choose a plan that is available in the county where I work.

___ I will be subject to a one time twelve (12) month waiting period for pre-existing conditions unless I have had prior creditable coverage for at least twelve (12) months and there has been no more than a sixty-three (63) consecutive day break in coverage between the termination of that coverage and the effective date of my coverage with the Public Employee Health Insurance Program. Any prior period of coverage that is less than twelve (12) months can be applied against the pre-existing condition waiting period. A comparison chart of the health insurance plans (PPO, HMO, POS and EPO) is printed in the *Health Insurance Handbook.*

___ I must indicate my level of coverage on my application.

- SINGLE – Employee only
- PARENT PLUS – Employee and Dependent Child(ren)
- COUPLE – Employee and Spouse
- FAMILY – Employee, Spouse, and Dependent Child(ren)

___ I have confirmed the availability of my payment options with my Insurance Coordinator.

- MONTHLY – Health Insurance premium is deducted from the last paycheck of the month.
- TWICE MONTHLY – Health Insurance premium is deducted equally from both paychecks. **If I fail to choose a payment option, the premiums will be deducted twice monthly, if available.**

- CROSS-REFERENCE – The participating employer contribution for the Health Insurance Premium for both eligible spouses is applied toward family or couple coverage, with the remaining premium deducted equally from each spouse's paycheck.
  - o NOTE: The husband and wife must be eligible for the employer contribution in the Public Employee Health Insurance Program.
  - o Certain requirements must be met in order to cross-reference. See your *Health Insurance Handbook* for a listing of those requirements.

___ Each Fall there is a defined Open Enrollment Period for health insurance that provides me the opportunity to make ANY type of change in my health insurance coverage that I wish to make. **NOTE: CHILDREN COVERED BY COURT ORDER OR ADMINISTRATIVE ORDER MAY NOT BE DROPPED FROM MY INSURANCE COVERAGE EXCEPT BY A SUBSEQUENT COURT ORDER OR ADMINISTRATIVE ORDER.**

___ Outside of Open Enrollment I will only be allowed to add or drop family members from my current plan and, in appropriate circumstances, change plans **within thirty (30) days of a Qualifying Event or sixty (60) days for newborns**. A list of Qualifying Events is printed in the *Health Insurance Handbook*.

___ It is my responsibility to contact my Agency's Insurance Coordinator no later than thirty (30) days of any event that may affect my coverage (See your Insurance Coordinator for a complete list of Qualifying Events).

___ The State offers a Premium Conversion program that allows me to pay my portion of the health insurance premium with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in health insurance, unless I sign a cancellation form.

___ My coverage will become **effective** on the first day of the second month following my employment or on a date stipulated by my employer.

___ If, sometime after my health insurance becomes effective, I and/or my covered dependents lose coverage due to termination of employment, divorce, or any other COBRA Qualifying Event, I/we have the right to continue health insurance benefits at my own expense under COBRA (see Initial Notice Memorandum on page 4-4).

___ If I decide that I DO NOT want the state-sponsored health insurance at this time, I can waive (decline) coverage by completing the appropriate sections of the application. If I waive coverage because I am covered under my spouse's plan, I will be allowed to enroll in a plan through the Public Employee Health Insurance Program if one of the following occurs:

1. my spouse's employer group health insurance terminates;
2. loss of eligibility;
3. the spouse's employer ceases contributing to the plan; or
4. if COBRA coverage is involved, the COBRA coverage expires.

Check with your spouse's health plan before waiving coverage. Some companies will not cover you if you are eligible for health benefits through your own employer.

___ If I waive coverage and desire to continue to waive coverage each year, I must complete a new application to waive during each Open Enrollment period. I understand that failure to complete an application to waive each year will result in my auto-assignment to the lowest cost Single Option A plan

available in my county of residence.

___ I may have the opportunity to enroll in the Flexible Spending Account programs, if applicable, no later than thirty (30) days of my date of employment. I have obtained the appropriate Flexible Spending Account information and application from my Insurance Coordinator.

___ I may contribute my own money into either the Medical or Dependent Care Flexible Spending Account. Once I have directed money into the Health Care FSA, changes are permitted for a HIPAA Special Enrollment Right or a Change in Status if the change is requested no later than thirty (30) days of the event giving rise to that right or change**.** Changes are allowed to the Dependent Care FSA with an approved Change in Status.

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___ Have you worked for any other agency participating in the Public Employee Health Insurance Program within the last sixty-three (63) days?
Yes ρ No ρ
If yes, please give name of agency and date terminated or transferred.

_____/_____/_____
Agency Date of Termination or Transfer

___ Are you retired from a state-sponsored retirement system?
Yes ρ No ρ

If yes, please specify which system:

_____ Kentucky Retirement System
_____ • County Employees Retirement System
_____ • Kentucky Employees Retirement System
_____ • State Police Retirement System
_____ Kentucky Teachers' Retirement System
_____ Judicial Retirement Plan
_____ Legislators Retirement Plan

I understand that if I do not sign my health insurance application by the required date, I will be automatically assigned to a plan that is available in my county of residence where the lowest cost Single Option A plan does not exceed the state contribution per month for the current plan year.
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I acknowledge that I have received copies of:

_____*Health Insurance Handbook*
_____Health Insurance Application
_____Flexible Spending Account booklet, if applicable
_____Flexible Spending Account Application, if applicable
_____Initial COBRA letter
_____Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Right Act
_____Other _____

I certify that I have had my Health Insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.

Employee Signature	**Date**	**Agency Representative**

EMPLOYEE SHOULD KEEP THE ORIGINAL NOTICE FOR HIS/HER RECORDS.

INSURANCE COORDINATOR SHOULD KEEP A COPY IN THE EMPLOYEE'S PERSONNEL FILE